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No Place Like Home

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Introduction

Home care policy still suffers from an absence of consensus about its principal goals, elements, and place in a continuum of care. Although attention is beginning to shift, health care financing and medical practice continue to emphasize a post-acute model of care, and the rationale for home care remains dependent upon claims for the impact of home care on institutional use and costs.

The explosion of Medicare home health costs in the last 10 to 15 years has forced the once obscure home care industry into an often harsh political and media spotlight. Both the Clinton administration and Congressional Republican leaders, hungry for ways to cut Medicare costs and balance the books, have targeted home care in the past few years. After President Clinton's health care plan was defeated in 1994, he turned his attention to trimming $16 billion from the Medicare home health care budget over the next five years, as outlined in the Balanced Budget Act of 1997 (BBA 97).

As a result of BBA 97, the home health care industry has experienced a dramatic shift in how home care services are reimbursed. In order to slash home health costs, the act called for a PPS, which would reward agencies able to hold down costs below set rates, to begin in 1999. While the Health Care Financing Administration (HCFA), Medicare's governing body, worked out the specifics, a temporary IPS that nobody in the home care industry likes, was put in place to serve as a transition to PPS. As we begin the millennium, PPS is nearly upon us.

A Personal Note

Two days after my father's hip replacement surgery, his orthopedic surgeon offered him two options. *Either* he could remain in the hospital for several days, undergoing close observation, intense physical rehabilitation to strengthen his weakened quadricep muscles, and infusion treatment, i.e., antibiotics administered intravenously for a mild upper respiratory noscomial infection, and have his Blue Cross/Blue Shield health plan pay over a $1,000 per day, *or* he could get the same treatment at home and pay less than $300 per day.

The choice was obvious. My father was hooked up to an IV in his study, given crutches, instructions on several stretching and aerobic exercises to complete at home, a referral to Sun Orthopedic Group, a prescription for pain medication, and was told by several nurses that they would miss his wisecracks and jokes. He considered himself "much better off'" than being confined to a hospital bed. He visited our family physician's office for blood work every few days and had two regular check-ups with his surgeon to monitor his progress.

For my father, the advantages of home treatment were comfort and convenience and the full-time moral support of our family. He was also able to keep his paper work from piling up. For the system, the reward is huge cost savings. New technology, the aging baby boomer population and incentives from insurers and employers have fueled a recent boom in home health care where treatment can be both high-tech and low-cost. Moreover, if President Clinton had his way, home health care benefits would be guaranteed as part of the minimum benefits package.

Scope of the Home Care Industry

THE WHO, WHAT AND WHEN OF HOME CARE

Home health care primarily involves services to homebound patients to promote, maintain, or restore a patient's health. A variety of patients are treated from patients who have recently been discharged from a hospital and temporarily require care during their convalescence, to people who have difficulty living independently due to the aging process or a chronic illness. Home health services typically include nursing; the administration of medications by a home health aide; speech, occupational, or physical therapy; counseling; dietary and nutritional services; help with daily hygiene chores; assistance with dressing; Meals on Wheels services; and bereavement care. Time with the patient can range from one hour a week to around-the-clock care.

The most common providers of care to individuals at home are home health aides, accounting for 31% of the industry (Freeman, 1995). Various professional health providers make up 32%, of which 20% are registered nurses, and 7% are licensed practical nurses. Personal and home care aides account for 13%, and the remainder is comprised of other specialized personnel such as physical therapists, social workers, and speech pathologists. According to employment data from the Current Employment Statistics survey, one in five jobs created in the non-farm economy since January 1988 has been in the health services industry (Freeman, 1995). Employment in home health care has risen by 168% (or 345,000 additional jobs) between 1988 and 1995. In contrast, employment in hospitals increased by 18% (580,000 additional jobs) in the same period. The Bureau of Labor Statistics has projected employment in the home care industry to increase by more than 500,000 jobs, or 128%, between 1992 and 2005 (Freeman, 1995).

Agencies range in size from those with a handful of clients to those with nearly 70,000. The average home health agency serves 180 clients (Center for Disease Control and Prevention, 1995). The home health industry nationwide is primarily nonprofit with 22% of agencies government owned, 37% nonprofit, and 41% proprietary. These proportions are nearly identical to those that currently exist in Pennsylvania. Over 1,100 home care agencies exist in Pennsylvania (McClure, 1999), of which approximately 350 are Medicare-certified, while 800 are not Medicare certified. Forty-one Medicare-certified agencies have gone out of business in Pennsylvania alone since February 1999.

HOME CARE COVERAGE

Home health agencies (HHAs) contract for a plan of care, and bill the patient or their insurer for visits and services. About 75% of private employers, as well as Blue Cross/Blue Shield plans, offer home health when a doctor orders the care and the carrier approves it. Normally, care must be in place of or an extension of hospitalization; few insurers will cover assistance with daily living unless it is given along with skilled nursing care.

More complex plans require the patient to be hospitalized first and the doctor's arrangements for home care be approved within several days of the patient's discharge. Some insurers use case managers to identify patients who might be able to receive treatment at home, and the insurers pay all costs. Otherwise, deductibles and co-payments will apply. Medicare Part A or Part B will pay 100% of approved payments for certain home care services if the patient meets all requirements: patient must need part-time or intermittent skilled nursing, or physical or speech therapy; be unable to leave their house without assistance; and have a written plan of care that has been signed by their doctor and accepted by a Medicare-certified home health agency. Hospitalization is not necessarily a pre-requisite. Part B covers 80% of durable equipment such as wheelchairs and oxygen. It is worth noting that few Medicare carriers will pay for antibiotic infusion like my father received. Medicare's coverage of home drug-infusion therapy is piecemeal; it may fall under Part A or Part B, depending on whether nursing care or equipment is involved and how the carrier interprets the benefit.

The Changing Home Care Market

A BRIEF HISTORY OF HOME CARE

The ways in which we think about home care have changed over time. A century ago, virtually all medical care was provided in the home, first by family members and other caregivers, and later by physicians making house calls (Risse, Numbers, and Leavitt, 1977). By the late 19th century, the emergence of modern scientific medicine, along with industrialization, urbanization, and immigration shifted the focus to care in hospitals and physicians' offices (Stevens, 1989). As a result, the home

quickly became irrelevant as a medical care site. By 1930, most medical care was delivered elsewhere. Nevertheless, physician house calls continued, at a declining rate, until the 1950s.

By World War I, the rise in chronic illnesses such as polio, arthritis, and tuberculosis, coupled with the steadily growing elderly population, presented numerous public health problems. Care for the chronically ill became a major problem for physicians who could do little to treat illnesses like heart disease and cancer. Hospitals began to bear the brunt of chronic cancer demands, while not being able to provide enough beds for the potentially curable. New interest in home care was stimulated as charity foundations and several prominent physicians and public health officials became interested in the treatment of chronic illnesses (Fox, 1989). Models of organized home care were soon developed in several cities. Home care became part of mainstream health care once again after the passage of Medicare and Medicaid in 1965. By design, Medicare was responsible for providing short-term post-acute care primarily through skilled services, while Medicaid ensured that preventive, skilled and non-skilled care would be provided to low income, chronically ill persons (Greenfield, 1968). Medicare's home health benefit was established to facilitate hospital discharge. Perceived as an alternative to hospital stays, it was not intended to cover long-term personal care.

From early in Medicare's history (Callender and LaVor, 1975), administrators and Congress have struggled with implementing home health coverage, seeking to balance the desire to minimize care in institutions with a concern about program costs. Too narrow a benefit would minimize use of home health as an alternative to hospital care. Too broad a benefit would extend program coverage beyond acute to long-term custodial care, thus exceeding Medicare's boundaries.

During the decade following 1965, the industry was dominated by efforts to fix and clarify ambiguities in the 1965 amendments. In 1967, a Social Security amendment switched home health care from an optional benefit to mandatory among Medicaid benefits (Greenfield, 1968). Amendments to this act in 1972 extended Medicare coverage to the nonelderly with disabilities and to persons with chronic renal disease. The revisions also streamlined the terms of Medicare program participation for home care agencies and eliminated Part B co-insurance requirements for home health users.

Home care expenditures had actually declined during this period, but spending seemed to take off in the mid-1970s. Homecare expenditures under Medicare and Medicaid roughly doubled in each program between 1975 and 1978 (Pillemer and Levine, 1981). Yet widespread belief was that public home health care benefits were too restrictive and that more health care agencies and personnel were needed to stem the rising tide of demand for home care. In 1977, the Congressional Budget Office (CBO) argued that a disproportionate amount of health care service funds for the elderly and disabled was going to nursing homes, and claimed that an estimated 20-40% of nursing home residents could be cared for less intensively in other settings

(Brown, 1988). The report described several reform options, including federal long-term care insurance and consolidation of all relevant program funds under a single federal agency. The most incremental and least expensive option involved liberalization of home care benefits under Medicare and Medicaid (Brown, 1988).

Doubts about home care spending were accompanied by concern over nursing home care. By 1975, nursing homes represented about 40% of all Medicaid expenditures and it became apparent that Medicaid nursing home expenditures were to triple in the next decade (Gomick and Hall, 1985). As a result, expectations about substituting home care for nursing home care grew.

By the late 1970s, projections about accelerated growth in the aging population were soon realized. Hospital and nursing home expenditures continued to climb at an alarming rate, while home health expenditures were also increasing under Medicare. Although this trend was a source of hope to those who advocated substituting home care spending for nursing home, it resulted in enormous fiscal anxiety. It became apparent that home care, once considered a cottage industry run by well-intentioned nurses and social workers, was now big business and, like the nursing home industry, seemed to be tainted by corruption and mismanagement.

Congressional hearings unearthed evidence that all was not well within the growing ranks of home health providers. Home care had lost its innocence. In addition, a 1981 report released by HCFA concluded that most home care could not substitute for expensive nursing home care. Weissert and coworkers (1980) found that although client contentment and satisfaction had improved, broadening of home care services was *not* associated with significant improvements in health and significantly *increased* the cost of care. Not only had home care lost its innocence, it had also become a perplexing topic.

HOME CARE REFORM: THE OMNIBUS BUDGET RECONCILIATION ACT OF 1980

Although there was no general consensus on the direction of reforms new policy was introduced as the home care industry entered the 1980s. Prior to 1980, Medicare beneficiaries could receive home health services only after a three-day hospital stay and the number of visits was limited to 100 per year. The Omnibus Budget Reconciliation Act of 1980 (OBRA) introduced long overdue changes in the Medicare home health benefit (Brown, 1988). First, the act removed existing limits on the number of allowable home health visits. Second, the amendments eliminated the existing three-day prior hospitalization requirement for home health benefits under Part A. Third, the deductible ($60) was eliminated under Part B. Fourth, for-profit (proprietary) home health agencies were no longer required to be certified for program reimbursement in states that licensed these agencies. Architects of these amendments hoped changes would encourage expanded use of home care services and discourage institutionalization. The results far exceeded any expectations. Essentially,

OBRA allowed more Medicare beneficiaries to be eligible for home health care and permitted more visits for those who qualified.

One of the most significant effects of the OBRA was that it opened up Medicare participation to proprietary home health agencies. By the mid 1980s, the number of for-profit agencies receiving Medicare reimbursement would increase six-fold (Benjamin, 1984). As for-profit agencies garnered a larger proportion of the home care market, there was considerable worry and some evidence—never entirely convincing—that proprietaries delivered more expensive care and were less likely to accept Medicaid clients than other agencies (Pillemer and Levine, 1981). Arguments about the place of profit in home care became even more relevant later in the decade as the number of proprietaries grew to one-third of all Medicare-certified home health agencies (Kenney and Dubay, 1992).

Consequently, hospitals and physicians became interested once more in home care. Hospitals moved into the home health business on a large scale; only freestanding proprietaries grew faster in number in the last decade (Egger, 1998). Hospitals have also been involved in the development and marketing of high-technology home care equipment in hopes of achieving their goal of creating a virtual hospital in the home. Although some physicians were investing in proprietary home health agencies, others began to talk about a revived role for house calls in community medicine (Steel, 1991). Many physicians and public health officials thought the reintroduction of physician home visits for selected populations and conditions made good social and clinical sense. However, opponents interpret efforts by hospitals and physicians to expand their roles in the home as the self-interested pursuit of new reimbursement opportunities and a diversion from designing effective chronic care at home. I will discuss the future prospects for hospital-owned and operated HHAs in a later section.

MEDICARE'S HOSPITAL PROSPECTIVE PAYMENT REIMBURSEMENT SYSTEM

The entire health care industry experienced unprecedented political pressure to contain costs, and especially Medicare public expenditures in the 1980s. The definitive health care policy change during the decade was the authorization of the Medicare PPS for hospitals under the Tax Equity and Fiscal Responsibility Act of 1982. Phased in between October 1, 1983 and September 30, 1984, PPS sought to improve efficiency by paying a fixed amount for treating cases in specific diagnosis-related groups (DRGS) [Preston, Chua, and Neu,1997]. Since the risk that costs would exceed DRG payments could have motivated hospitals to discharge patients sooner than medically warranted, physician and hospital reimbursements were separated. Therefore, hospital profit is higher the shorter the stay, but the physician's fee is lower. To compensate for shorter stays, hospitals began discharging patients to skilled nursing facilities or home health agencies for post-acute care. Attention was then focused on the post-hospital experience.

Several studies have documented increases in the post-acute use of home health services following the implementation of hospital PPS (e.g., Valvona and Sloan, 1988).

While overall increases in the proportion of Medicare enrollees who use home health services and the average number of home health visits per person were relatively small, they were much greater than they would have been without PPS. The introduction of PPS for Medicare hospital services appeared to have increased Medicare expenditures for home health by 25% (Kenney, 1991). By 1988, home health care was the fastest growing source of Medicare expenditures. Between 1983 and 1994, total Medicare outlays for home health care increased from $1.6 billion to $12.7 billion, raising home health's share of total Medicare costs from 2.8% to 7.8% (HCFA, 1996). Costs per beneficiary increased from $78 to $352 in 1993 dollars during this period (Bishop, Ritter, Skwara, Brown, and Thornton, 1995). Finally Medicaid expenditures for home care, barely half a billion in 1982, more than quadrupled by 1988 (Reilly, Clauser, and Baugh, 1990).

Before PPS, there were few incentives for hospitals and physicians to utilize home care because both were reimbursed for all of the days patients remained in hospitals (Steel, 1991). With prospective payment, hospitals began to face discharge incentives whether home care was available or not. As the length of Medicare hospital stays declined, it became clear that shortened stays were the result of reimbursement reform. For better or worse, home health care was the major beneficiary.

LONG TERM EFFECTS OF OBRA AND PPS

The combined effects of the OBRA in 1980 and the implementation of PPS for hospitals in 1982 caused a boom in the home health care industry. To counteract the rapid increase in Medicare's home health expenditures, HCFA tried to impose guidelines on its intermediaries.

Restrictions appear to have been particularly aggressive in response to the increased demand for home health care that followed the implementation of prospective payment for hospitals. The key to these restrictions, and consequently the key to keeping the home health benefit short-term, has been interpretation and enforcement of coverage rules, both by HCFA and by its intermediaries. Since HHAs were financially liable for uncovered claims, the availability of services tended to closely reflect the coverage rules. In the course of the 1980s, these rules were challenged in Congress and the courts for the vagueness of HCFA guidelines, the inconsistency of interpretation across areas and the specific interpretation of eligibility criteria. Particularly troublesome, was that it was meant to be "homebound" or "part-time" or "intermittent" and in need of "skilled care." Alongside disputes about what these terms meant, came charges that arbitrary benefit limits and claims denials were used to limit expenditures. The U.S. Attorney General Accounting Office (1996) reported that denial rates increased from 3.4% in 1985 to 7.9% in 1987.

After losing a class action lawsuit in 1988, in which a court ruled that its policies were too restrictive, HCFA was forced to make changes in its home care coverage policy (Moon, 1993; Bishop and Skwara, 1993; U.S. General Accounting Office, 1996). As of July 1, 1989, HCFA both broadened and clarified its interpretation of

skilled care and the terms on which beneficiaries could receive it. Skilled care was explicitly extended beyond specialized services to include judgmental services such as skilled observation, patient assessment and management, and evaluation of patients' care plans. The meanings of "part-time," "intermittent," and "homebound" were clarified to facilitate, rather than limit, provision of care at home. As before, people who qualified as satisfying these conditions became eligible not only for skilled services, but also for other home health services, including support services provided by home health aides.

As a result of these changes, Medicare home health spending began a steady and sharp climb into the 1990s (Egger, 1998). By 1996, one in ten Medicare beneficiaries received Medicare-covered home health services, and the number of visits per user nearly tripled between 1983 and 1996. In addition, the number of home health care agencies in the United States tripled between 1986 and 1997.

Medicare continued to be the single largest revenue source by far for home health care agencies, with two-thirds of most agencies' revenue coming from Medicare. But just as HCFA helped initiate a boom in the home health care business in 1980, its action to impose IPS for Medicare home care reimbursement under BBA 97 threatened to end the boom and send the home health care roller coaster into a downward spiral.

Conversion to PPS?

THE IPS MESS

Home health care had been spared immediate conversion to prospective payment because no one knew how to implement prospective payment for long-term care and because retrospective reimbursement per visit with cost limits had been workable. However, as Medicare home care spending soared from $4.7 to $17.2 billion between 1990 and 1997, easily the fastest growing segment of Medicare, HCFA found renewed motivation to evaluate alternatives to the current system of cost-based reimbursement. Reform efforts were aimed at saving Medicare $16 billion over five years and helping balance the budget (BBA 97). HCFA aimed to develop a prospective payment form of reimbursement in the home health industry which would establish a fixed, predetermined payment per unit of service, adjusted for each type of case. In an effort to save money in the interim, HCFA decided to impose IPS, a stop-the-bleeding solution.

Effective in October 1997, IPS drastically changed the way Medicare had been reimbursing home health care agencies. IPS maintained a cost-based reimbursement system but drastically reduced payment to home health providers. Prior to IPS, agencies were reimbursed at either the lower of their actual costs or a ceiling, and then set at 112% of the wage-adjusted mean costs per visit (Hahn, 1998). With IPS, agencies began to be reimbursed at either the lower of their actual costs, or a reduced cost-per-visit limit set at 105% of the median cost per visit. This was adjusted for number and

mix of visits the agency provided, or the aggregate per-beneficiary limit set at 98% of the average allowable cost per patient for all agencies in the government's fiscal year ending in September 1994 (Bitoun-Blecher, 1998).

The reimbursement changes under BBA 97 have clearly had a dramatic impact on the industry. The Medicare IPS had abruptly cut the reimbursement payment for services to Medicare patients in 1998 to 2% below the levels that were in place during fiscal year 1993-94 (Hahn, 1998). Provisions requiring the use of 1993-94 data were enacted so that Congress could achieve federal government savings from the home health benefit. Not surprisingly, industry insiders labeled IPS a disaster. Per beneficiary limits were deemed unfair because different types of providers and certain geographic areas were affected differently, and IPS was considered unfair because it set equivalent payment reductions across the board, regardless of whether the provider had been efficient. For most home health agencies, revenue reductions ranged from 15% to 22% below 1997 limits. Industry sources (Hahn, 1998) estimated that 65% of free-standing home health agencies have costs that exceed the payment limits imposed by the IPS. The impact of the IPS is expected to be far greater on hospital-based agencies because many hospitals routinely allocate overhead costs to their home care businesses.

When Congress enacted widely varying per-beneficiary limits that were not based on either quality of care or the cost-effectiveness of home health providers, it ironically rewarded the more costly HHAs and penalized the home health provider who had been cost-effective. The new beneficiary limits were implemented by basing the calculations on agency-specific costs per beneficiary in 1993-94. As a result, the new system rewards the home health providers who were making many more visits and incurring as many costs as possible. This is especially troubling since the average number of home care visits per patient varies wildly from place to place in the United States (Egger, 1998). For instance, the average number of visits in Los Angeles is 158, while the average number in Pennsylvania is 44.

Although the home health industry had been united in working with Congress and the Clinton administration to adopt a fair PPS for home health services, IPS retained cost reimbursements and added even more defects to the old system. Industry-wide complaints and lobbying efforts garnered sizable Congressional support to change the IPS in the summer of 1998, but when Congress finally acted before adjourning in October, its actions fell far short of what HCFA was seeking. Congress only delayed the 15% cut until October 2000 and increased reimbursement payments to 106% of median per-visit costs instead of 105% of median costs. Unfortunately, this legislation is only helpful to those agencies with costs well below the national average.

Congress established the adjusted reimbursements based on its need to cut $16.1 billion in home care costs from the Medicare budget. However, some insiders believe HCFA miscalculated home care utilization projections and that Congress' IPS reimbursement levels actually would reduce the home care portion of Medicare expendi-

tures by $50 billion. By increasing reimbursement payments to 106%, savings would be $49 billion rather than $50 billion (National Association for Home Care [Egger, 1998]).

EFFECTS OF IPS

While Congress had good intentions in trimming some of the fat from the Medicare home health care budget, it cut off too much, too fast. As a result of IPS, many of the nation's 10,500 Medicare agencies have complained they are hemorrhaging cash. Few experts doubt the necessity of payment reforms, but HCFA's plan has caused severe problems. Many low-cost agencies can't cover their expenses under the new rates. Nearly all the reserves the Visiting Nurses Association of Eastern Pennsylvania (VNAEP) had built up have been sapped dry the last several months to compensate for the decreased reimbursement rates under IPS. It gets by month-to-month on Medicare payments, which account for about 75% of its current revenues, over 5% below its percentage of Medicare reimbursement prior to July 1998 (King, 1999, April). This year, revenues are projected to sink further.

Paradoxically, while efficient not-for profit operations like the VNAEP suffer, many higher-cost and start-up agencies reap a windfall. This is because Congress mandated basing rates 75% on each agency's historical costs and 25% on regional costs (Hahn, 1998). Therefore, agencies with heftier expenses get heftier rates. And finally most agencies open since 1993, have received payments based on the national cost average, which can be significantly more than local rates.

WHEN PPS?

As the debate over whether PPS is the best and fairest way to reimburse agencies continues, the industry is left in turmoil. Adding to the confusion is the fact that changes will undoubtedly arise but no one is exactly sure what the changes will be. No one—not even HCFA—really knows if and when PPS will be implemented. HCFA set an October 1999 implementation date for a home health care PPS, but Congress delayed it to October 2000, after it became obvious that HCFA's difficulties in dealing with Year 2000 computer challenges would probably delay that date. However, some home care insiders think that Y2K glitches are not the only thing holding up HCFA's move to PPS (McClure, 1999, March). McClure points out that conversion to PPS has been bantered about since the mid-1980s, yet it has not been formally introduced. The complexity of it leads him to believe HCFA is not confident how to properly implement it. This uncertainty makes it impossible for agencies to plan ahead and restructure for the future.

Financing Alternatives in Home Health Care

The challenge of home health payment reform is to counter existing incentives for inefficient production and excess volume, while protecting Medicare beneficiaries' access to high-quality and cost-effective care. How we shall pay for home health

remains a thorny issue. Home health is acknowledged as being both cost effective and patient-centered, yet as the volume of services increases, the efforts to contain the costs of these services increases so greatly that Medicare beneficiaries often receive barely adequate or less than adequate levels rather than appropriate levels of care (McClure, 1999, March).

Nevertheless, these efforts have resulted in the development of a number of possible reimbursement approaches for home health care. For example, payments can be set prospectively for each visit provided, each month of care, each episode of care, or each month of program enrollment. Each of these approaches allows varying amounts of control and provides different incentives to providers.

EPISODE OF CARE

The recent explosion in the number of visits per episode of care (units of service larger than a single visit) is the primary source of the large increases in Medicare home health costs (Benner, 1998). Setting a fixed reimbursement rate prospectively for home health visits would not reverse this trend, even if it did lower unit costs. A prospective reimbursement based on diagnosis is one alternative. Like hospitals, home care could be paid based on a patient's diagnosis group, which relates to illness and care. For example, a newly diagnosed insulin-dependent diabetic may require an average of six visits for teaching and monitoring. The case payment could be structured as six visits times the visit rate with a discount factor. The discount factor would account for cases that require fewer than six visits. HHAs would then schedule visits to correspond with the teaching goals of the case rather than maximizing the number of visits.

PER MEMBER PER MONTH

One risk-sharing model is capitation per enrollee per month. Under this model, the HHA receives a capitated fee, say one dollar per member per month, for each enrolled member of the HMO who lives within their coverage area. The HHA is then responsible for covering all of the home care needs of the HMO population. Private insurers have had capitation plans with HHA for years; could Medicare reimburse HHAs per Medicare beneficiary served per month?

Such an arrangement would produce several outcomes. First, HHAs would receive a monthly cash flow and avoid the administrative costs of billing and collection. Second, agencies then become the exclusive provider of home care services to the HMOs. Third, agencies must learn to manage utilization internally. This model makes HHAs both a provider and a quasi-insurer. However, this reimbursement method, unlike a fee-for-service model, requires close attention to cost-use by HHAs. When prices are set, great consideration needs to be given to prior home care expenditures. Many insurers are also requiring a provider to have an all-inclusive charge that includes both services and products. Once again, a thorough review of a member's past utilization and experience becomes the framework for rate setting. Fourth, HHAs

must have management information systems in place in order to monitor service in real time rather than retrospectively. Lack of experience by HHAs in this type of rate setting could leave the agency non-competitive if priced too high, or at substantial financial risk if priced too low. Fifth, they must have the financial back up to absorb losses if utilization is more than anticipated. Finally, in the first year or two of a capitation plan, it is advisable to develop a risk-sharing formula with the insurer, until utilization is stabilized (Brault, 1988).

CAPITATION PER ENROLLED MEMBER

Another method of capitation is per enrolled member. For example, some visiting nurse services have captitated AIDS case management programs (Brault, 1988). This program pays a monthly capitation for home care for every enrolled AIDS patient. The capitation is paid by such commercial agencies as Blue Cross/Blue Shield. There is a risk-sharing formula devised to place the agency at risk, with some stop-loss limitation. The monthly rate applies whether or not the client requires home care in a given month. This particular model is managed by specialists in AIDS care that allocate more care to acutely ill patients and restrict care to those who are in a relatively healthy state. The HHA faces both the financial and clinical outcome responsibility for each case.

BUNDLED SERVICES

One way to avoid the many telephone calls and reports needed to monitor use, is to sell a package of services rather than a per-visit rate. For example, a HHA may have a package for perinatal care that would be sold at one price, giving you the flexibility to visit without pre-authorization from an insurer. Based on expected use and costs of a specific diagnosis, services are bundled and packaged. Again, the agency must have a thorough understanding of utilization before pricing the package.

Unfortunately, the only widespread bundled payment encompassing home health care appears to result in significantly less service to patients (Shaughnessy, Schlenker, and Hittle, 1994). A recent survey of HMO members found that 17% of those receiving bundled home health care felt that they did not receive enough of such care and 70% of these beneficiaries reported adverse consequences, including worsened conditions, delayed recovery, out-of-pocket payments, and family burdens (Nelson, Brown, Gold, Ciemnecki, and Docteur, 1997).

PROSPECTIVE PER VISIT

When prospective rates are set per visit, the provider has an incentive to provide that visit at lower cost in order to retain the difference between the cost and reimbursement rate as profit (or surplus). Under this system, the patient, not the provider, is at risk for decreased level and amount of care. Therefore, the payer has the incentive to monitor service use and is likely to assess each visit for eligibility and

coverage in order to assure that it pays only for those visits for which it has an obligation to pay and that the patients receive the appropriate amount of care.

It is important to note that there is a basic flaw in any payment approach or limit based on the number of visits: visits can vary widely in content and cost (Bishop et al., 1995). For example, skilled nursing for intravenous therapy typically takes much longer and may require a more experienced staff than visits to administer insulin or draw blood. Similarly, health aide visits can be very short (e.g., to turn a bed-bound patient) or can last several hours (to help patients with bathing, toileting, and eating). Furthermore, whether agencies provide a given type of care in multiple short visits or in a single longer visit is often at their discretion.

COPAYMENT

The use of copayments has also been suggested as a cost-containment measure for reimbursing home care agencies. Requiring Medicare home health recipients to pay for a portion of their bill or to subscribe to supplemental insurance that covers the copayment would naturally decrease Medicare expenditures. The patient would assume more risk and would be weary of over-utilization. Although it may sound like a good idea, this financing mechanism would unfortunately create even more hardship for Medicare recipients who are more likely to be poor and much less likely to have supplemental insurance.

HOSPITALS AND HOME CARE

In this time of home health cutbacks, most hospital executives are putting their basic assumptions up for grabs if they own a home health agency. Before IPS, it appeared hospital-based agencies had an unfair advantage over independents. Hospital-based agencies had a boundless referral base, were able to cost shift quite effectively, and passed high administrative and overhead costs off to Medicare (O'Donnell, 1989). However, under the current and pending changes in Medicare reimbursement previously discussed, home care tends to add costs rather than absorb overhead. The changes turned home care into a commodity requiring higher volumes but with lower margins. Since many hospital-based agencies do not provide unique services in their markets, freestanding competitors can offer similar care—often at lower prices. In addition, federal fraud probes continue to stir up trouble. Taken together, it is obvious the playing field has been leveled. Staying in home health care will not be easy for hospitals.

Hospitals that choose to stay in the home care game will need to invest more dollars in their agency to remain competitive and meet the expectations of the marketplace (McClure, 1999, March). According to several insiders (McClure, 1999, March; O'Donnell and Hoss, 1998), hospitals have several options. First, they must understand the real financial effects of home care on hospital finances—PPS demands this. Since I found data measuring the effects of home care on hospital fi-

nances and operations generally lacking, I predict there is little if any information to gauge the indirect benefits. Second, if there is no financial advantage in keeping home care a part of hospitals, it might be wise to create a freestanding business or consolidate satellites. With the implementation of IPS, it was not uncommon to see not-for-profit HHAs (e.g., Visiting Nurses Association of Eastern Pennsylvania) turn to hospitals for help. Such relationships are most beneficial when the HHA is allowed to focus on being an efficient agency free of the hospital's administrative encumbrances. As a result, hospitals must consolidate all home care businesses under a single executive reporting to the CEO to maintain coordination and avoid overlapping. Along this line of thought, hospitals that own or are affiliated with several agencies of overlapping service areas should consolidate them under a single corporate entity to spread out overhead costs. For example, Tenet Healthcare of Santa Barbara, CA underwent a massive consolidation, closing 20 of 75 units in 1998 (Bitoun-Blecher, 1998). Tenet's strategy was to serve the same patients with fewer satellites. So far the streamlining strategy appears to be an effective one. Despite the closings, Tenet has only lost two towns where another agency has picked up the slack.

Third, hospitals that cannot justify the HHA's financial contribution to the hospital should consider whether out-sourcing home care to selected companies makes more sense. PPS has forced independent HHAs that previously provided a broad spectrum of services to consider this option and it has been a successful cost containment strategy (King and Ray, 1999, March). Hospital-based agencies, which naturally care for the sickest and costliest patients, typically spend between $16 to $35 more per visit than independents (Bitoun-Blecher, 1998). This was not an important piece of data when Medicare covered costs, but in the past several years reimbursement rates have been based on the free-standing agencies' lesser expenditures. Out-sourcing services would also allow HHAs more flexibility when negotiating contracts with health plans and facilitate economies of scale.

Fourth, many larger private hospitals that own and operate separate medical equipment businesses might be wise to consider out-sourcing since few are successful in running such operations (O'Donnell and Hoss, 1998). Finally, hospitals should utilize their affiliations with HHAs more effectively. By restructuring discharge planning and social services as a complete case management department within the HHA, care can be fully integrated into overall care management strategies.

Home care does not make sense for all hospitals. Hospital CEOs must consider how much of their reserves they are willing to forfeit, the level of local competition, and the access problems they would create if they leave the home care market. The trend of hospitals looking beyond their four walls has been mistakenly called "diversification." In fact, hospitals do not need to diversify in the classic business sense. In today's health care environment, they will be forced to make more mutually exclusive choices regarding components of health care they need and which they can afford to operate.

Conclusion

Congress reasoned there is no place like home health to squeeze Medicare savings. Consequently, both agencies and the frailest patients are suffering. I doubt few industry insiders and politicians would argue that changes in Medicare reimbursement for home care are not needed, but the verdict is still out on how to create a fair, appropriate reimbursement methodology.

Despite the current state of turmoil that IPS and fear over PPS has created, the future of the home health care industry remains solid. No matter what changes occur, home health care still represents one of the most cost efficient types of care, when compared with inpatient or skilled nursing facility costs. With managed care pushing more acutely ill patients out of hospitals earlier, sub-acute care facilities are likely to continue playing an important role in the continuum of care.

Some Congressmen have readily acknowledged IPS causes serious problems (Benner, 1998). Politicians hope to fix this mess—without spending more money—by throwing out historical costs and instead pegging rates to a blend of national and regional averages. They (Senators Edward Kennedy, D-MA; Wes Watkins, R-OK; J.C. Watts, Jr. R-OK; John Breaux, D-LA, and others) also want to set aside funds to pay increased expenditures for extra costly patients. The goal is to reward efficient providers serving sicker patients and slim down inefficient ones.

Still, in the interim, more frail, extremely costly patients will lose access to care. Medicare's home health benefit was intended to cover only short-term, post-acute care, not the long-term needs of the chronically ill. But it has been steadily stretched by agencies and patients, as well as by Congress and the courts, because most recipients have no other means to pay for long-term care. Medicaid, the only other public payer, is stingy and highly variable by state.

There are no guarantees that prospective payment will be any better—or even ready by next year. Tests of the system at about 100 agencies have been promising. Agencies receive a global fee for each 120-day episode of care and are paid per visit if care lasts longer. Visits have dropped by 17%, with no evidence of lower quality (Benner, 1998). However, HCFA still has not figured out how to match payments to patients' risk of needing services, and that is critical. While Nancy DeParle, HCFA administrator, vows that the system will be ready on time, most experts are dubious. This means agencies and patients may have to live with the flawed interim system longer than expected.

To some observers, the turmoil reflects lingering uncertainty about how much home care the government should cover. The Medicare benefit has expanded without much scientific basis for determining who should get services and in what combination, according to several veteran home care researchers (Weissert, Lesnick, Musliner, and Foley, 1997). It appears home health care is an area ripe for cutbacks, but we simply do not know how much expenditures can be cut before patients begin to suffer.

As an optimist, I believe this state of turmoil provides the opportunity to appropriately restructure the industry into a much more efficient model. Many have and will suffer from the metamorphosis, but when it is all over, the industry will be more efficient with a stronger infrastructure. With the advent of modern medical technology, the variety of home care services provided will most likely increase, while the number of visits could decline. Furthermore, many home care visits could be substituted for by a phone call. Rather than sending an aid on a three-hour journey, a phone call to a patient's home could serve just as effectively to remind him/her about taking his/her medications on a daily basis.

The industry will find the most sensible, efficient, and effective way to care for a patient simply because there are no other alternatives. When the metamorphosis is over, the home care industry will have created new care mechanisms—a holistic package of care where HHAs are not reimbursed for a visit, but are paid for taking care of the patient.

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